PROMISSOR

# Wisconsin Nurse Aide Program

# MEDICATION AIDE REGISTRY APPLICATION

This application reports the successful completion of a Wisconsin-approved medication aide training program by a nurse aide previously included on the Registry. Successful completion of the medication aide training program OR approval of a Challenge Examination allows a nurse aide to administer medications in a federally certified skilled nursing home. The personal information will only be used to determine your nurse aide employment eligibility. Providing your Social Security number is voluntary; however, the number is needed to process your application. Social Security numbers are used to identify nurse aide employment eligibility for current and prospective employers. This application will not be processed if it is incomplete, unsigned, or illegible. Allow two (2) weeks for processing your completed application. To verify the processing status of your application, access Promissor's Web site at www.promissor.com. Wisconsin Nurse Aide Registry information is available twenty-four (24) hours a day, seven (7) days per week.

**COMPLETE, SIGN, AND MAIL THIS FORM TO:**
Promissor – Wisconsin Nurse Aide Registry
PO Box 13785
Philadelphia, PA 19101-3785

## PLEASE PRINT NEATLY IN BLACK INK OR TYPE THE FOLLOWING INFORMATION

| Social Security Number | Date of Birth | Gender |
|---|---|---|
| _____ - _____ - _____ | _____ / _____ / _____<br>Month Day Year | ☐ Female ☐ Male |

- If your CURRENT NAME has changed from the name listed on the Wisconsin Nurse Aide Registry, attach a *photocopy* of a document that proves your name (for example, driver's license, marriage certificate, divorce certificate, etc.).
- If you are reporting a SOCIAL SECURITY NUMBER CORRECTION, please attach a *photocopy* of a document that proves your number (for example, Social Security card, employee check stub or Internal Revenue Service return).

**Name Change?** ☐ Yes ☐ No

***CURRENT* Full Name:** *(Last, First, Middle Initial)* DO NOT USE NICKNAMES

_____
LAST FIRST MIDDLE INITIAL

***PREVIOUS* Full Name, if applicable:** *(Last, First, Middle Initial)* DO NOT USE NICKNAMES

_____
LAST FIRST MIDDLE INITIAL

**Current Mailing Address:** *(Street/PO Box Number)*

_____
STREET/PO BOX NUMBER

_____
CITY STATE ZIP CODE

**Home Telephone Number:** (  ) _____ **Work Telephone Number:** (  ) _____

**Employer Name:** _____

**Employer Address:** _____

***I verify that the information on this form is true and correct.***

**Signature–Nurse Aide:** _____ **Date:** _____

## MEDICATION AIDE INSTRUCTIONAL PROGRAM INFORMATION

| Instructional Program Name | Medication Aide Program Number | Date of Program Completion |
|---|---|---|
| | ☐☐☐☐☐-MA☐ | _____ / _____ / _____<br>MONTH DAY YEAR |

☐ A copy of the Medication Aide Training Program Certificate, verifying the nurse aide's successful completion of a Medication Aide Training Program approved by the Wisconsin Department of Health and Family Services.

***I verify that the information on this form is true and correct.***

**Signature–Medication Aide Instructor:** _____ **Date:** _____